

TAMANG SAGOT
PhilHealth Circular 2015-035

Guiding Principles of the Z Benefits

1. What are the goals of the Z Benefits?

Overall, the Z Benefits aim to provide financial risk protection to members and beneficiaries and achieve better health outcomes of patients by providing a rational intervention to standardize care and improving the system delivery of services in the country

2. What are the Objectives of the Guiding Principles?

- a. Update the minimum standards of care or the mandatory services based on evidence and current standards of practice that are applicable and transferrable to the local setting;
- b. Standardize the forms used for pre-authorization and claims filing;
- c. Establish the Z Benefits Information and Tracking System (ZBITS);
- d. Institute quality standards, performance indicators and measures for monitoring of the Z Benefits, in collaboration with key stakeholders, experts and the Reference HCIs;
- e. Conduct regular policy review of the Z Benefits based on a valid and acceptable methodology;
- f. Integrate marketing and promotional activities for the Z Benefits that shall promote and increase public awareness;
- g. Promote individual patient empowerment through the Member Empowerment Form (ME Form) by encouraging patient participation in health care decision-making to improve patient adherence to agreed treatment plans in order to achieve good clinical outcomes and patient satisfaction;
- h. Emphasize the multidisciplinary-interdisciplinary team (MDT) approach to patient care in partnership with the health care professionals in the contracted HCIs;
- i. Introduce the concept of a patient navigation into the Z Benefits in partnership with key stakeholders, experts and patients;
- j. Introduce the field monitoring of the Z Benefits;
- k. Initiate contracting of the Z Benefits to all capable HCIs.

3. What is the Z Benefits Information & Tracking System or ZBITS?

The ZBITS is the information tracking system that shall be developed by the Corporation in collaboration with relevant stakeholders and experts. It aims to track all Z patients in contracted HCIs from diagnosis up to improvement, death or lost-to-follow-up and during referral of patients to other contracted HCIs.

Once ZBITS is developed, the data elements identified by the reference HCIs shall be included in the ZBITS Module of the HCI Portal. As of November 2015, the ZBITS is currently in the development stage.

4. What are the specific objectives of the ZBITS?

The ZBITS aims to facilitate the following:

- Submission and approval of application for pre-authorization of Z patients
- Gathering of data to generate routine reports relative but not limited to the following: benefits utilization, benefits payment, support value and out-of-pocket expenses
- Monitoring provision of minimum standards of care and other requirements
- Determination of clinical outcomes of care such as mortality, complications and patient satisfaction
- Generation of relevant data which may be useful for policy research, planning, benefits enhancement and quality improvement, among others.

5. Who shall be allowed to access the ZBITS?

The contracted health care institutions (HCI) shall designate at least one (1) Z Benefits Coordinator per Z Benefit Package to access the ZBITS Module. The HCI shall send a request to their respective PhilHealth Regional Office regarding access to ZBITS.

6. What are the responsibilities of the Z Benefits Coordinator?

The Z Benefits Coordinators are responsible for:

- Providing guidance and navigating Z patients by facilitating timely access to services required for the Z Benefits.
- Coordinating with PhilHealth relevant matters pertinent to the Z Benefits availment.
- Encoding pertinent information of all patients diagnosed with the illness/condition covered by the Z Benefits whether or not the patients fulfill the selections criteria
- Other duties and responsibilities that may be assigned by the contracted HCI such as ensuring completeness and accuracy of all attachments needed for pre-authorization, claims filing and reimbursement.

7. What are the general rules for availing of the Z Benefits?

- All eligible PhilHealth members are qualified to avail the Z Benefit packages
- A member should have at least one (1) day remaining from the 45-day annual benefit limit upon approval of the pre-authorization
- PBEF shall be the primary proof of benefit eligibility
 - A PBEF that says “NO” means that the patient MAY NOT be eligible. The HCI portal shall provide the information for documents to be submitted to PhilHealth. These supporting documents shall be attached to the PBEF.

8. What does pre-authorization mean?

Pre-authorization is the gate-keeping function that PhilHealth has put in place to screen patients, ensuring only those who satisfy the selection criteria for the specific disease get to avail of Case Type Z benefits. Hospitals have to seek pre-authorization from PhilHealth on behalf of their patients prior to delivery of services.

9. What are the general requirements for a patient to be pre-authorized to avail of the Z Benefits?

- The patient should have not previously undergone treatment for exact same condition in the Z Benefit package that is being availed of. This includes laterality for applicable conditions.
- Approved pre-authorization is valid for 60 calendar days from date of approval (unless otherwise specified)
- Contracted HCIs are responsible for tracking the validity of their approved pre-authorizations
- Contracted HCIs shall inform PhilHealth immediately if pre-authorization requests lapsed. They can submit a new pre-authorization checklist and request, if needed.
- Currently, pre-authorization requests are submitted manually to the LHIOs or to the Benefits Administration Section. Eventually, this will be automated.
- Photocopy of Member Empowerment Form is attached to the application for pre-authorization
- Approval shall be made within two (2) working days. The approved/disapproved Pre-authorization Checklist & Request shall be sent back to the contracted HCI.
- Patients with approved Pre-authorization Checklist and Request shall automatically be deducted 5 days from the 45 days annual benefit limit.
- Patients with only 1 day remaining from the 45 days annual benefit limit shall still be eligible to avail of the Z Benefits
- An approved Pre-authorization Checklist Request guarantees payment of the initial tranche of the Z Benefit package provided that the mandatory services for the specified treatment phase are given to the patient and all other PhilHealth requirements are complied with.

10. Who enrolls patients to the Z Benefits?

Contracted HCIs shall be responsible for enrolling only NEWLY diagnosed patients into the Z Benefits

11. Are there exemptions to the NEWLY diagnosed cases?

Yes. Among these are the following:

- end stage renal disease (ESRD) requiring kidney transplantation or peritoneal dialysis;
- limb amputation requiring external lower limb prosthesis (Z MORPH),

- coronary artery bypass graft surgery (CABG)
- congenital heart disease and
- existing hip conditions requiring surgery

12. Are there cases where a patient can avail of the services for the Z Benefits without submission of a pre-authorization request?

Yes. PhilHealth allows availment of the Z Benefits for the following emergency conditions:

- Kidney transplantation from a non-living donor;
- Hip fixation requiring multiple screw fixation
- Administration of chemotherapy in children with working diagnosis of acute lymphocytic leukemia (standard risk), provided that appropriate specimen samples, i.e., bone marrow, CSF and blood specimens have been collected for the timely and accurate diagnosis of the child with leukemia

In such cases, the application for pre-authorization is submitted after provision of mandatory services.

Other policies on pre-authorization are listed below:

- For the Z Benefits on kidney transplantation, the HCIs may require eligible patients to have a Certification from their social service office that such patients can maintain anti-rejection medicines for the next three (3) years
- For the Benefits on breast cancer, the clinical stage requirements for approval of pre-authorization shall follow clinical stages for early breast cancer; Stage 0 to Stage III-A
- For the Z Benefits on cervical cancer, the pre-authorization and the package rates will be based on treatment modalities:
 - Stages IA1 to IIIB – Chemotherapy, cobalt and brachytherapy (low dose)for P125K
 - Stages IA1 to IIIB – Chemotherapy, linear accelerator & brachytherapy (low/high dose) P175K
- If the deadline of submission of the Pre-authorization Checklist & Request falls on a weekend or a Holiday, the contracted HCI shall comply with submission of requirements on the first working day after the weekend or holiday.
- It is the contracted HCIs' responsibility to remind the patients to update their premium contributions to ensure that these patients are eligible during the time or provision of the mandatory service/s when the HCI has not yet submitted the pre-authorization request to PhilHealth.
- If the delay in the submission of the Pre-authorization Checklist and Request is due to natural calamities or other fortuitous events, the contracted HCI shall be accorded an extension period submission of 60 calendar days.

- Laboratory results shall not be required as attachments to the Pre-authorization Checklist and Request. These should be attached instead to the patient's chart and should be available during field monitoring of the Z Benefits.

13. What are the rules in filing of claims for the Z Benefits?

- Contracted HCI must render all the mandatory services and other services in the context of the MDT approach to patient care. The list of services may be found in Annex J of the circular.
- Submit completely accomplished required forms.
- Results of diagnostic and laboratory tests are NOT required as attachments to the claim.
- There shall be NO direct filing by members.

14. What are the documents needed in filing claims for the Z Benefits?

- Z Benefit transmittal form (Annex H)
- Original copy of approved Pre-authorization
- Photocopy of accomplished ME Form
- PhilHealth Benefit Eligibility Form (PBEF) print-out during pre-authorization
- Claim Form 2
- Checklist of Mandatory services (Annex C) for the corresponding tranches
- Tranche requirements checklist (Annex E)
- Photocopy of the operative record for surgical procedures
- Photocopy of the completely accomplished Z Satisfaction Questionnaire (Annex D)

15. What are the instances where claims for the Z Benefits may be denied?

- Claims shall be denied payment in the following instances:
 - a. If a mandatory service was not provided by the contracted HCI;
 - b. If the required signatures in the forms are missing;
 - c. Incompletely filled out forms;
 - d. Incomplete attachments such as ME Form, Z satisfaction Questionnaire, (Except for the PD First Z Benefits), operative record(for orthopaedic implants bearing the code/serial or lot/batch number of the medical device), original copy of the approved Pre-authorization Checklist and request and other forms required under the Z Benefit packages.
 - e. Late filing

16. What happens when claims for the Z Benefits are denied?

When a claim is denied, the patient and/or the contacted HCI may submit a letter of appeal to their respective PhilHealth Regional Offices.

17. What are the rules for payment of claims?

- For Tranche 1, only claims with approved Pre-authorization Checklist and Request shall be processed and paid accordingly.
- Claims for succeeding tranches will be processed, provided that the preceding tranche payments were made except for the following:
 1. Breast Cancer patients who completed neo-adjuvant chemotherapy prior to surgery where filing of claims for tranche 1; and
 2. PD First Z Benefits (Z Benefits for end stage renal disease requiring peritoneal dialysis)
- All claims shall be paid to the Contracted HCI

18. How does PhilHealth monitor the implementation of the Z Benefits?

- Performance indicators and measures to monitor compliance to the policies of the Z Benefits of all contracted HCIs shall be established in collaboration with relevant stakeholders and experts. These shall be incorporated in the Health Care Provider Performance Assessment System (HCP PAS) of PhilHealth.
- This may also include field monitoring of specific Z packages. The method and its corresponding tools and consent forms are found in Annex L of the circular and are developed for purposes of benefits monitoring, benefits enhancement, policy research and continuous quality improvement.

19. How are the policies for the Z Benefits reviewed and updated?

- PhilHealth conducts a regular policy review of the Z Benefits collaboration with stakeholders, PROs, experts, and patients as needed.
- Contracted HCI may provide PhilHealth the pertinent data for cases that they assess to be complicated, that consequently necessitated the provision of additional services other than those included in the specific Z Benefit packages
- A form for List of Additional Services (Annex P) may be used for policy research and benefits enhancement.

20. How does PhilHealth heighten public awareness of the Z Benefits?

- Promotional activities shall be undertaken in accordance with the integrated marketing and communication plan of PhilHealth.
- Patients and stakeholders shall be given the opportunity to participate and contribute to the improvement of marketing and promotional activities of the Corporation that are pertinent to the Z Benefits.

21. How can HCIs be contracted to provide the services for the Z Benefits?

- The specific policy and guidelines for contracting capable HCIs and the minimum requirements for renewal of contracts for the Z Benefits are stipulated in PhilHealth Circular 14, s. 2015 (Guidelines for Contracting HCIs as Z Benefit Package Provider)

22. When is the effectivity of this circular?

This Circular shall take effect on **October 30, 2015**.